

APPENDIX 6

**Office of the Governor
Division of Medicaid**

Limited English Proficiency Request Form

Report Date _____ Report Time _____

DOM Staff Person _____

Bureau/Region Office _____

Reporting Period _____

Name of Requester _____

Address _____

Telephone Number _____

Language Spoken _____

Type of Assistance Requested _____

Contract Interpreter Yes _____ No _____

Non-Contract Interpreter Yes _____ No _____

**Office of the Governor
Division of Medicaid**

**Limited English Proficiency Request Form
MONTHLY SUMMARY REPORT**

Report Date _____

DOM Staff Person _____

Bureau/Regional Office _____

Reporting Period _____

Number of Requests _____

Language Spoken (Please number each) _____

Number of Contract Interpreters _____

Number of Non-Contract Interpreters _____

Language Line Service Requests _____

(This summary should match Language Line Service invoice from Accounting and Finance for authorization for payment)

**Office of the Governor
Division of Medicaid**

**Limited English Proficiency Request Form
QUARTERLY SUMMARY REPORT**

Report Date _____

DOM Staff Person/Bureau Regional
Office Location _____

Reporting Period _____

Number of Requests _____

Language Spoken (Please number each) _____

Number of Contract Interpreters _____

Number of Non-Contract Interpreters _____

Language Line Service Requests _____

Types of Services Requested _____
